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AUTHOR Nickens, John M.; Trofholz, Harlan F.
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ABSTRACT

This report provides a discussion of strategies for containing the costs of health insurance programs offered at Florida's community colleges. Introductory material outlines the problem of spiralling health care costs and the impact upon the community colleges. In addition, some of the strategies for containing costs are discussed; e.g., increasing deductible expenditures, requiring a second opinion for surgery, forbidding weekend admissions, using home health care, and requiring pre-employment physicals. Next, broader plans which incorporate a variety of strategies for curtailing cost increases are highlighted, including charging a fee for service in health insurance schemes; and the establishment of a Health Maintenance Organization to provide pre-paid health protection on an "as needed" basis without charge. The remaining sections examine life and health programs currently in operation in 19 Florida community colleges; compare Florida programs with those in operation in California; and provide an overview of interviews with key informants in each of the colleges represented on the Florida Community/Junior College Inter-Institutional Research Council. Finally, the report presents a summary, conclusions, and recommendations. A request for bids for health insurance plans for the Florida Community College System is appended. (HB)

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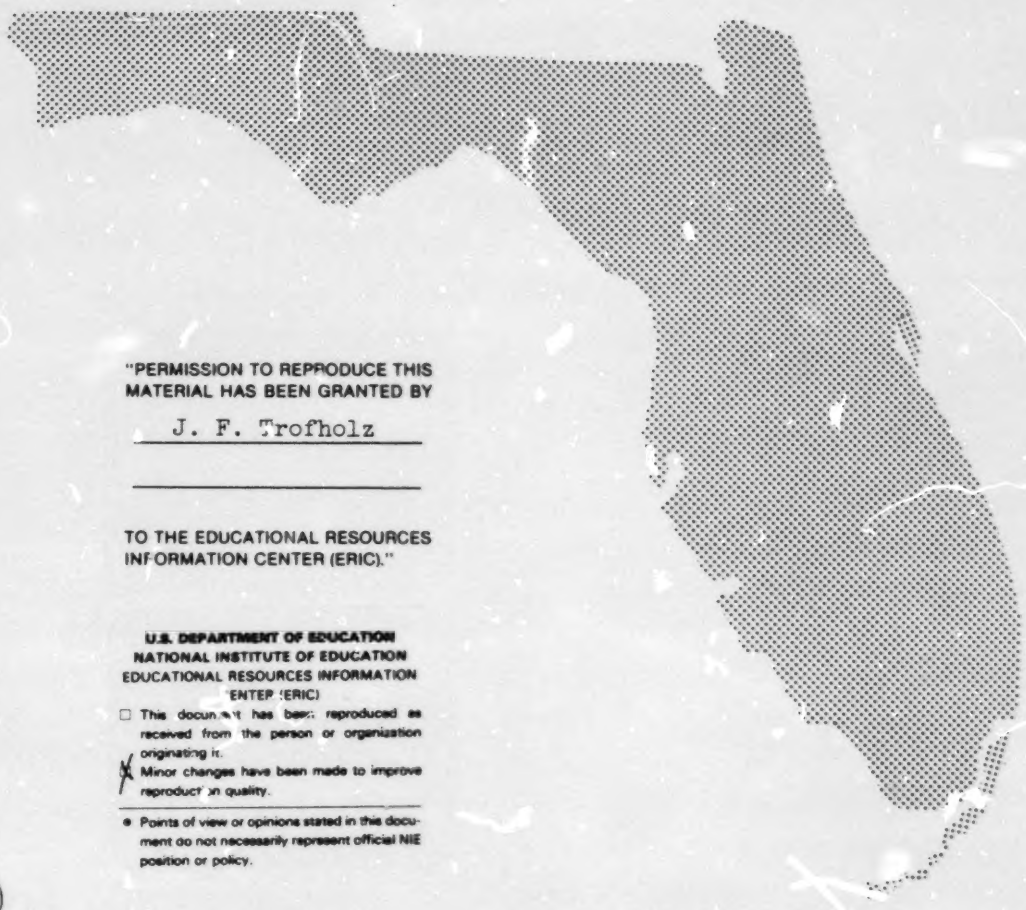

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COOPERATION FOR PROGRESS THROUGH RESEARCH
florida community junior college inter-institutional research council

Recommendations for Cost Containment for Florida Community Colleges Health Insurance Programs

by

John M. Nickens
Harlan F. Trofholz

A Research Report:

The Florida Community/Junior College
Inter-Institutional Research Council

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INTRODUCTION

Fringe benefits for employees have become a major element in the recruitment and maintenance of a competent work force. Because the community college system usually is unable to compete with private enterprise on a salary schedule basis, emphasis has been placed on providing superior fringe benefit programs. Life insurance and health insurance are two key fringe benefits that the college system has used to protect the employee's welfare and promote job stability.

In recent years the cost of benefit programs (particularly health insurance) have been increasing at a rate beyond the assumption capability of the college budget. Many colleges have increased deductibles and coinsurance participation percentages or reduced benefits to avoid additional increases. The immediate result of these changes has been to diminish the value of the benefit programs-programs designed to compete for competent personnel.

Representatives of the Florida Community/Junior College Inter-Institutional Research Council (IRC) decided in September, 1984 to study health programs in the Florida community college system, and to determine if solutions could be found to contain the rapidly increasing benefits costs.

The literature disclosed that many steps are being taken to contain the spiraling costs for health care. The federal government has taken the lead by restricting payments made under medicare, resulting in reduced revenues for hospitals and other health care providers. They, in turn, attempt to recover these federally mandated reductions by increasing charges to private insurance plans, including the programs of the community colleges.

The increasing cost of health insurance has resulted in several strategies for cost containment. These strategies include:

Increasing deductible and out-of-pocket limits,

Permitting no deductible on outpatient surgery,

Requiring second opinion for surgery,

Seeking concurrent review of hospital stays,

Testing on an outpatient basis,

Forbidding weekend admissions,

Establishing a bonus program for staying well,

Using home health care, and

Requiring pre-employment physicals.

Broader plans are emerging that incorporate a variety of strategies for curtailing cost increases. Some of the most promising will be described.

Fee for Service in Health Insurance

Charges for medical services are paid for by one of two methods. Charges are determined and paid as received (fee-for-service) or a monthly predetermined fee is made to a health provider organization in exchange for nonchargeable health care services. An example of the latter would be a membership in a health maintenance ogranization.

Most medical charges are reimbursed on a fee-for-service basis. Enthoven (1980) wrote that through 1976 some 92-95% of the population of the United States had some form of health insurance coverage and that approximately 90% of all reimbursements were made on a fee-for-service basis.

The fee-for-service concept is advantageous for the doctor Enthoven (1980) said, because fee-for-service gives the doctors maximum control over their incomes and wide latitude to set their own fees. He further stated that while their gross

incomes account for 18% of the total health care spending, physicians directly controlled 70% of all health care expenditures. They are the primary decision makers in the health care system. Dresnick (1979) reported that most doctors have no idea what hospital costs, planning costs, and other ancillary patient-care costs really are. Opponents of the fee-for-service system of payment encourage changing to a prepaid system. Luft (1981) reported that the current system of fee-for-service payment of providers and extensive third-party insurance coverage insulates both providers and consumers from concern about the rising cost of medical care.

Proponents of the present fee-for-service system counter with various statistics supporting its continuation. Allen (1978) reported that 40% of the average increase in hospital expenses during the last decade are accounted for by improvements in quality. Aiken (1979) stated that official data show clearly all the most frequently used indices of the health of the American people in the 1970s were better than ever before; the improvement continued throughout the decade. Many of the current problems of American health care are in fact the price of success.

The Health Maintenance Organization

The alternative to fee-for-service insurance coverage is some form of prepaid health protection which provides patient care on an "as needed" basis without charge. The generic term applied to this prepaid concept is Health Maintenance Organization (HMO). Ellwood (1971) wrote that this term was coined in the early 1970s as a part of a strategy to win Nixon administration support and Congressional approval for prepaid health care as an alternative to the predominant fee-for-service (FFS) system with third-party reinmbursement.

On December 29, 1973, President Nixon signed the Health Maintenance Organization Act of 1973 which authorized $375 million to be used in creating a nationwide system of HMOs. The Department of Health, Education, and Welfare

was to supervise this growth by conducting feasibility studies and making loans to qualified public and nonprofit organizations providing health care. The Act also mandated standards for HMOs and required employers to offer employees the option of enrolling in HMOs if available.

Cammeyer (1979) described the HMO as

> a legal entity which provides basic supplemental health services in a specific geographic area to voluntarily enrolled members in exchange for prenegotiated periodic prepayments. Members who are provided services at the HMO's facilities or from hmo physicians are not charged on a fee-for-service basis. The physicians, or other health professionals, provide health services to members, and the HMO assumes the financial risk, on a prospective basis, for providing specified health services. (p. 49)

According to Wetherille and Nordby (1974) the key features of the HMO were:

1. The HMO assumes a contractual responsibility to provide or assure the delivery of a stated range of health services. This includes at least ambulatory care and inpatient hospital services.

2. The HMO serves a population defined by enrollment in the plan.

3. Subscriber enrollment is voluntary.

4. The consumer pays a fixed annual or monthly payment that is independent of the use of services. (This does not exclude the possibility for some minor charges related to utilization.)

5. The HMO assumes at least part of the financial risk or gain in the provision of services. (p. 2)

Wetherville and Nordby (1974) defined four basic types of HMOs. They were the Individual Practice Association (IPA), the Prepaid Group Practice (PGP), the Staff Model HMO, and the Network HMO. The IPA provides ambulatory treatment in offices of participating physicians on a previously determined fee-for-service schedule. In 1978, there were about 70 IPAs in operation with about 1 million members. Although there are numerous varieties of IPAs, Luft (1981) concluded that there was no evidence that cost for enrollees in IPAs are any lower than for people with conventional insurance. Enthoven (1980)

proclaimed that perhaps the most important lesson the the IPA is that if economic survival in the face of competition is at stake, physicians will impose on themselves controls they would never dream of accepting if imposed by government.

The PGP is an organization of physicians, working together, who agree to furnish a predetermined group of voluntary members with comprehensive health care in exchange for a predetermined per capita fee. There are also numerous varities of financial agreements under this concept. The PGP has been more successful than the IPA. In 1978, there were about 130 PGPs in the United States with a total enrollment of 6.4 million members. The largest system is the Kaiser-Permanente Medical Care Program with about 3.5 million members in seven states.

The Staff Model HMO is very similar to the previous group with the exception that the physicians are employees of the HMO.

The Network HMO is a combination of the previous forms. It is utilized to provide programs to employers who have employees in various geographic locations where the health care facilities vary.

The HMO concept is gaining in popularity. This popularity is based on some facts that indicate that this health protection system is less costly than the fee-for-service method. Enthoven (1980) stated that there have been about 50 comparative studies done since 1950. Luft (1981) reviewed and analyzed these studies and concluded that the costs in PGPs were some 10-40% lower. Most of the cost difference could be attributed to hospital-use rates 25-45% lower than those of groups with traditional insurance.

Riedel (1975) reported in a study of federal employees in Washington, D.C., that the hospital patient days per 1,000 persons per year for Group Health Association members (HMO) was 59% of those insured by Blue Cross on a fee-for-service basis.

In June 1981, the U.S. Bureau of Labor Statistics reported HMO membership to be 10.3 million. Taube (1984) stated that by April 1984 HMO membership had grown to 12.5 million. He predicted by the next decade that membership will reach 50 million.

The HMO concept is not without problems. Ellwood (1984) stated that only 3% of insured workers had chosen to participate in the HMO. He reported that growth has been hindered by four key factors.

1. Opposition from the medical profession
2. Competition from health insurers
3. Cost of establishing an HMO, and,
4. Reluctance of employees to restrict choice of physicians to a particular group. (p. 53)

Luft (1981) further reported that HMO opponents say income is inversely related to services; therefore there is an incentive to reduce service. Opponents do concede that there is also an incentive to provide service and avoid larger prospective costs.

The future of the HMO appears favorable. The federal and state governments view the HMO as a viable solution to the inflating costs of fee-for-service programs. To insure the continual growth of the HMOs, the federal government has developed financial and operational guidelines. These guidelines, when met, serve as an endorsement by the Office of Health Maintenance Organizations in the Department of Health and Human Services. The stamp of approval has provided a positive basis for additional growth of this health care concept.

Present Programs in the Florida Community Colleges

The first phase of this study was the compilation of information on current benefit programs in the Florida Community College system. Information on the life and health programs of 19 colleges was obtained at the Florida Community College Risk Management Consortium administrative office located on the campus

of Santa Fe Community College in Gainesville. Program information on the remaining 9 colleges was obtained by telephone inquiry, and published reports on college benefit programs. This information is presented in Table 1.

A comparison of existing college programs revealed that no two college programs were exactly alike. However, there were major similarities which demonstrated a philosophical agreement between the colleges regarding the overall design of a benefit plan.

All but three of the community colleges provided a comprehensive major medical plan with an 80/20% coinsurance clause. Two utilized an 85/15% coinsurance clause, while one varied the clause depending on the type of medical expense. The maximum claim limit ranged from $250,000 to $1,000,000, to unlimited. Maximum "out of pocket" figures varied slightly with some applying per person and some quoted as a limit per family.

Every college health plan was written with a deductible provision on the major medical deductibles which ranged from $100 to $500 per employee per year. If dependent coverage was also elected a second deductible applied to one, and in some cases two, dependents. It had been the trend in recent years to increase deductibles and let employees absorb more of the initial cost in order to avoid additional premium increases. This had been marginally successful, but some colleges feel they have increased deductibles to limits which create an unfair financial burden on lower paid personnel.

Some colleges provided 100% coverage on initial hospital claims. Basic claims were paid on a scheduled basis before the major medical provision and deductible apply. The Manatee Community College program contained this feature. The health plan was for $250,000 major medical with an 80/20% coinsurance clause after a basic program schedule. A $100 deductible per employee and one dependent applied to the major medical. The maximum "out of pocket" limit was $850. The basic program limit paid all expenses up to a scheduled limit. After this

TABLE 1

Health Benefit Programs with College (C) and Employee (E) Costs

COLLEGE HEALTH BENEFITS PROGRAM	COST EMP	COST DEP
Brevard - Unlimited with 80/20% clause after basic, $150 employee deductible, $100 dependent deductible, $2,500 maximum employee out of pocket	$ 89(C)	$106(E)
Broward - Unlimited with 80/20% clause, $100 employee deductible, $200 dependent deductible, $3,000 maximum employee out of pocket	127(C)	76(E)
Central Florida - $1,000,000 with 80/20% clause, $500 employee deductible, $500 dependent deductible (1 dependent) (2 or more dependents), $1,500 maximum employee out of pocket	65(C)	60(E) 125(E)
Chipola - $250,000 with 85/15% clause, $100 employee deductible, $100 dependent deductible	67(C)	104(E)
Daytona - $1,000,000 with 80/20% clause, $200 employee deductible, $200 dependent deductible, HMO (Florida Health Care) option available	60(C) 70(C)	66(E) 71(E)
Edison - Unlimited with 80/20% clause, $200 employee deductible, $500 maximum coverage per individual, $1,000 per family	74(C)	68(E)
Florida Junior College - $1,000,000 with 80/20% clause, $200 employee deductible, $200 dependent deductible, $1,000 maximum per individual (Self-insured)	84(C)	78(E)
Florida Keys - Unlimited with 80/20% clause, $100 employee deductible, $100 dependent deductible	81(C)	129(E)
Gulf Coast - Unlimited with 80/20% clause, $150 employee deductible, $150 dependent deductible (deductible does not apply to hospital expenses)	36(C)	58(E)
Hillsborough - $1,000,000 with 80/20% clause, $200 deductible per person (3 per family), $5,000 maximum per family, 2 HMO --CIGNA and Tampa Bay HMO CIGNA Tampa Bay	96(C) 65(C) 85(C)	129(E) 106(E) 125(E)

Table 1--(continued)

COLLEGE HEALTH BENEFITS PROGRAM	COST EMP	COST DEP
Indian River - $1,000,000 with 80/20% clause, $100 employee deductible, $100 dependent deductible (deductible does not apply to hospital expenses), includes dental, $1,000 maximum out of pocket	$101(C)	$143(E)
Lake City - $1,000,000 with 80/20% clause, $250 employee deductible, $500 dependent deductible, $1,250 maximum out of pocket per person	78(C)	143(E)
Lake Sumter - $250,000 with 80/20% clause, $100 employee deductible, $100 each dependent deductible (1 dependent), (2 or more dependents), $1,000 maximum out of pocket per individual	41(C)	39(E) 59(E)
Manatee - $250,000 with 80/20% clause after basic, $100 employee deductible, $100 dependent deductible, $850 maximum employee out of pocket	76(C)	136(E)
Miami-Dade - $500,000 with varied consumer clause--60-100% depending on type of expense, $200 employee deductible, $200 dependent deductible, $300 hospitalization deductible, (waived with pre-certification), 2 HMO--AV-Medical (HMO) and CIGNA Health Plan, (1 dependent), (2 or more dependents), CIGNA Health Plan (HMO) (Self-insured)	121(C) 100(C) 74(C) 1(C)	155(E) 100(E) 135(E) 133(E)
North Florida - Unlimited with 80/20% clause, $50 employee deductible, $50 dependent deductible, $1,000 maximum employee out of pocket	73(C)	86(E)
Okalossa - Unlimited with 80/20% clause, $200 employee deductible, $200 dependent deductible (with 2 dependents), (with 3 or more dependents)	70(C)	135(E) 177(E)
Palm Beach - $250,000 with 80/20% clause, $100 employee deductible, $100 per individual, $830 employee maximum out of pocket	63(C)	80(E)
Pasco Hernando - $500,000 with 80/20% clause, $100 employee deductible, $100 dependent deductible, $500 employee maximum out of pocket	69(C)	92(E)
Pensacola - $250,000 with 80/20% clause, $100 employee deductible, $100 dependent deductible (1 dependent), (2 or more dependents), $700 employee maximum out of pocket	94(C)	71(E) 101(E)
Polk - $1,000,000 with 80/20% clause, $100 employee deductible, $100 dependent deductible, $500 employee maximum out of pocket	56(C)	61(E)

Table 1--(Continued)

COLLEGE HEALTH BENEFITS PROGRAM	COST EMP	COST DEP
St. Johns - $1,000,000 with 80/20% clause, $200 employee deductible, $200 dependent deductible (3 per family) (no deductible to hospital expense with second surgical opinion), $1,200 maximum out of pocket per individual	$ 74(C)	$ 70(E)
St. Petersburg - $1,000,000 with 80/20% clause, $200 employee deductible, $200 dependent deductible (1 dependent) (2 or more dependents), $700 maximum out of pocket per individual,	101(C)	101(E) 142(E)
2 HMO--CIGNA and Tampa Bay HMO CIGNA	74(C)	
(1 dependent)		74(E)
(2 or more dependents)		116(E)
Tampa Bay		
(1 dependent)	66(C)	76(E)
(2 or more dependents)		111(E)
Santa Fe - $1,000,000 with 80/20% clause, $200 employee deductible, $200 dependent deductible, $1,000 maximum out of pocket	84(C)	73(E)
Seminole - $250,000 with 80/20% clause, $100 employee deductible, $100 dependent deductible, $1,000 maximum employee out of pocket	75(C)	112(E)
South Florida - $250,000 with 85/15% clause, $100 employee deductible, $100 dependent deductible, $600 maximum employee out of pocket	115(C)	150(E)
Tallahassee - $1,000,000 with 80/20% clause after $2,000 of hospital, outpatient, and emergency charges are paid in full, $200 employee deductible, $200 dependent deductible (3 per family), (1 dependent), (2 or more dependents)	70(C)	86(E) 126(E)
Valencia - Unlimited with 80/20% clause, $100 employee deductible, $100 dependent deductible, $600 maximum employee out of pocket	88(C)	97(E)

limit was reached, the employee (or dependent) deductible applied and then assumed 20% of all expenses until the total expenditures reach $850. The insurance carrier paid 100% of the usual and customary expenses beyond this stated "out of pocket" limit up to $250,000.

Most of the colleges did not have a basic plan because cost was greater. Most college plans applied the deductible and coinsurance provisions on a "first-dollar" claim basis.

Some of the major medical plans had no maximum claim limit. The lowest limit purchased by the colleges was $250,000. Many purchased greater limits because the additional cost was minimal--usually less than $1.00 per month per employee for $1,000,000 coverage.

Only 4 of the 28 colleges reported offering HMO programs to their employees in addition to a fee-for-service program. Miami-Dade offers two HMO programs and has approximately 45% of its employees enrolled. St. Petersburg Junior College also offers two HMO programs. Over 70% of its employees have opted for these HMOs. The college policy was to contribute to the cost of the employee coverage based upon the lowest plan quotation. Therefore, the college contributed $66.04 for the employee coverage regardless of the plan selected. The remaining two colleges each had less than 25% of their employees opting for HMO coverage. Telephone interviews with college personnel at these colleges reported that they preferred to remain with the fee-for-service program if the cost was not too much greater because they could elect their own doctor and medical facility. Each college also reported that the HMO offering was a very recent offering for their personnel and that many were not familiar with services offered.

Premiums for the health programs fluctuated considerably with no consistent pattern in relation to size of college program insured. Personal contacts with the various colleges accounted for these variations. Because each college is

separately experience rated, small colleges that had large claims were immediately confronted with substantial premium increases. Larger colleges were not as receptive to large claim disruption, but they still reiterated the problem of excessive large and numerous claims.

Most of the colleges admitted to a lack of an organized effort for cost containment. Each did respond in the positive when inquiry was made regarding the need for cost controls.

All of the community colleges paid the health premiums for their employees. Three of the community colleges (Miami-Dade, Gulf Coast, and Santa Fe) contributed to the cost of dependent health-care--paying approximately 50% of the dependent charge.

Ten of the colleges reported offering dental maintenance programs as part of their health plans. In most cases, these plans were underwritten by separate insurance companies as preventive maintenance programs with maximum annual benefits not to exceed $1,500.

Differences in Florida and California Program Structures

The health and life programs written by the college districts in California are more liberal benefits than Florida plans. The California programs were generally designed with lower deductibles or lower coinsurance requirements. HMO alternatives were also offered in each of the districts.

Unique features of the California plans included such items as ambulance and air ambulance payments to $200, prescription drugs for flat fees ranging from $1.00 to $4.00, HMO physician house calls for $3.50 to $5.00, life insurance available for dependents, and premiums for dependent health coverage paid in large part, or fully, by the colleges.

The liberal approach to benefits and premium payments by California districts created some financial burdens for these districts. Telephone interviews with their managers disclosed that abuses of plan provisions and disregard for medical

charges have resulted in rapidly increasing rates. The HMO rates were substantially less than the fee-for-service rates, but the districts continue to pay the full premiums for any of the plans selected. This fact has contributed to employee disregard for medical expenses.

Key Informant Interviews

Key informant interviews were conducted at each IRC college, with the support and assistance of the college's IRC representative. Specifically, an initial telephone contact was made with each IRC representative. The interview forms were sent to the representative for distribution to key informants in the classification requested. It was requested that this form not be completed by the key informant until the time of the on-campus interview which was scheduled approximately two weeks later.

A hypothetical health and life program confronted with a 20% rate increase was described in the interview forms. This information provided the basis to present questions to be evaluated by the key informant. Each question with the exception of #3 and #6 requested selection of a preferred solution. Questions #3 and #6 differed in that they requested a ranking of the possible choices. The key informants included 12 business office representatives, 16 career staff representatives, 8 faculty representatives, and 6 risk managers.

The participants in the interviews expressed sincere interest and demonstrated a positive attitude in their comments and responses. Personal contact with the informants demonstrated that the employees of the college system are very concerned about the life and health programs and are desirous of seeing measures taken to contain the rapid growth of expenses and premiums. The interview instrument provided specific responses from which program recommendation could be made. The results are reported in Table 2.

Questions 1 and 2 were designed to determine respondent's attitude toward deductibles. A variety of options were presented which could be selected in

Table 2

Key Informant Interview Responses to Cost Containment Options

	Business Office	Career Staff	Faculty	Risk Manager	Total
1. I think the college should:					
a. Eliminate major medical coverage, which could cancel the need for increase and save an additional $20 per month per employee. Add savings to salaries.	0	0	0	0	0
b. Increase deductible from $100 to $500 and avoid need for increase.	2	6	2	4	14
c. Employer absorb $15 per month increase on employee and employee absorb $16 per month increase on dependents.	6	9	5	2	22
d. Employer absorb total increase but deduct cost from salary budget.	4	1	1	0	6
e. Cancel life insurance and use funds to pay health insurance.	0	0	0	0	0
2. To help contain costs the college should:					
a. Increase deductibles from $100 to $200 or higher and apply to both illness and accident.	11	13	5	6	35
b. Leave the deductible at $100 but change coinsurance from 80/20% to 60/40%.	0	1	1	0	2
c. Leave the deductible and coinsurance clause as is but remove the limit on employee "out of pocket."	1	1	2	0	4
d. Decrease claims by restricting coverage to specifically named illnesses.	0	1	0	0	1

Table 1 (continued)

	Business Office	Career Staff	Faculty	Risk Manager	Total
3. Following is a list of new cost containment proposals; please rank them 1 through 10 in order of preference to your constituency. (1 most important - 10 least important).					
a. Increasing deductible and out-of-pocket limit.	9	5	7	2	6
b. No deductible on outpatient surgery.	5	3	1	4	3
c. Second opinion surgery.	1	1	4	2	1
d. Concurrent review of hospital stays.	2	4	6	5	5
e. Preadmission testing on outpatient basis.	7	2	2	1	2
f. No weekend admission.	8	9	5	5	8
g. Establish bonus program for staying well.	3	6	3	3	4
h. Surgogation.	9	8	9	6	9
i. Home health care.	4	5	8	7	7
j. Require pre-employment physical or health questionnaire.	6	9	10	8	10
4. Assume all of the cost containment proposals in item #3 are adopted, would it be appropriate to require an employee to pay a larger part of a medical bill if the employee refuses to comply with or ignores the containment prerequisites? (i.e., apply a 60/40% coinsurance clause instead of an 80/20% clause).					
a. Yes.	12	14	6	6	38
b. No.	0	2	2	0	4

Table 2 (continued)

	Business Office	Career Staff	Faculty	Risk Manager	Total
5. If HMO enrollment fees were the same as your present fee-for-service plan premiums, would you prefer an HMO to your present plan?					
a. Yes.	7	9	4	1	21
b. No.	5	7	4	5	21
6. Following is a list of coverages that generally may be added to a program. Please rank 1 through 9 in order of preference to your constituency (1 most important - 10 least important).					
a. Dental care	3	1	1	2	1
b. Drug and alcohol rehabilitation.	8	8	8	6	8
c. Orthodontic care.	7	7	6	5	7
d. Vision care.	5	2	2	4	4
e. Disability income (short term, i.e., one year).	2	3	5	2	3
f. Disability income (long term, more than one year).	4	4	4	3	5
g. Hospital income.	6	6	7	5	6
h. Life insurance.	1	5	3	1	2
i. Other (specify)_____.	9	9	9	9	9
7. Which of the following approaches to medical care would your constituency prefer?					
a. Health maintenance organization (HMO).	4	3	2	1	10
b. Preferred provider organization (PPO).	2	3	2	2	9
c. Present optional doctor and hospital program.	6	10	3	3	22

Table 2 (continued)

	Business Officer	Career Staff	Faculty	Risk Manager	Total
d. No preference.	0	0	0	0	0
e. Other (specify)_____.	0	0	1	0	1

8. Would your constituency prefer to unite Florida Community Colleges under a central program to benefit economically from larger numbers and dollars, or do you feel that each college should purchase locally to maximize individual preference in insurance options?

a. Unite under a central program.	11	10	8	5	34
b. Purchase locally.	1	5	0	1	7
c. No opinion.	0	1	0	0	1

9. Given that colleges united as in item 8 would your constituency favor:

a. One plan for all colleges.	1	3	0	0	4
b. Optional program (two or more that the college may select from for its employees).	7	11	4	5	27
c. Establish benefit dollars for each employee and permit employee to make choice.	4	2	3	1	10
d. Other program (specify)_____.	0	0	1	0	2

lieu of increasing the deductible. Question 2 disclosed that respondents would rather pay a premium increase than increase the deductible. Question 2 selections, however, almost unanimously elect to increase the deductible rather than restrict overages of the plan.

After considerable discussion about cost containment, the participants ranked the various proposals in Question 3. The results indicated conclusions which can be of value for each college. One of the choices offered was a monetary bonus for staying well. This choice was ranked sixth out of nine choices while normally less convenient cost containment restrictions were given higher priority.

This concern for control is further supported by Question 4 where 38 out of 42 people endorsed monetary penalties for noncompliance with cost containment provisions.

Respondents to Question 5 were equally divided in their selection or rejection of the HMO concept. Several of the informants were dubious of the value of prepaid HMO services stating that they believed the services would be inferior. Others indicated that they would not be willing to give up their freedom to choose their own doctor. Most of the respondents had not been familiar with the HMO concept before the time of the interview. With 21 of 42 informants in favor of this new concept, it is reasonable to expect expansion of this health care procedure in the community college system.

The next step in the interview pertained to the ranking of benefits in Question 6 that may be included as part of the basic health plan. Life insurance was included as an elective and respondents were asked to assume that their present health plan did not include life insurance. The ranking numbers by type of employee were totaled with the sums determining overall rank of each benefit. The ranks of each category of employees were totaled with the lowest sum receiving the highest overall rank. As an example, the risk managers' sum

of the ratings on life insurance was 11. This sum was less than the combined totals on other benefits, therefore, it was ranked as their number one choice. Business officers also selected life insurance as their first choice. Faculty representatives rated the choice third and career staff personnel rated this choice fifth. The combined total of the ranks was ten which was the second lowest sum and was then assigned the second overall rank.

It is surprising to note that dental care received the highest rank. Most dental programs limit annual benefits to $1,500 or less per year. Nevertheless, each of the colleges visited that did not have dental programs felt strongly in favor of the benefit. Those colleges with the plan felt the benefit was a popular and worthwhile addition for their employees.

The balance of the rankings appears reasonable and could be used as a priority guide when colleges consider providing additional benefits for their employees.

The results of Question 7 are not too surprising. The majority of the informants preferred the freedom of choice offered by choice C (present optional doctor and hospital program). Verbal discussion of this point also demonstrated that these people were generally willing to pay slightly more for this type program even though it includes deductibles and coinsurance requirements.

The final portion of the interviews disclosed that a large majority favored the uniting of the community colleges under a central program. This central program should design two or more plans that the college administration could adopt for offering to their employees.

These final questions answered by the informants support the concept of the existence of the Florida Community College Risk Management Consortium. The general response does propose that the variety of 28 programs presently in existence be replaced with two or more well-designed and controlled benefit programs.

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The problem of this research study was to analyze the rapidly inflating costs of Florida community college employee health and life benefit programs and determine the feasibility of recommending a consolidated plan to be administered by a central consortium.

Information pertaining to the following questions was researched:

1. What type programs are presently being purchased by the Florida Community College system?
2. Is it feasible for the colleges to design their own protection programs?
3. What features and coverages would community college personnel like to have included in a medical program?
4. Who should bear the costs of medical benefit programs--the college or the employee?
5. Would it be feasible for colleges to financially "self-insure" these programs and not buy specific insurance in the commercial market-place?

A review of the literature was completed which disclosed broader options to be considered by employers in designing employee benefit

programs. Some options presented were a repeat of previous questions, and were restated to emphasize their importance.

1. Should the college participate in a separate or consolidated program?
2. Should the college participate in a fee-for-service or a prepaid medical program?
3. Should the college include dental and optical coverages in the basic program?
4. Should the premium be paid by the employer, the employee, or be shared by both?
5. Should the college purchase specific insurance or self-insure?

The Florida statutes and Florida State Board of Education Regulations were studied to determine types of benefits allowed by law. Information regarding health programs at each Florida community college was obtained to study the variety of programs available and determine legal compliance.

A comparison of Florida Community College programs with three California Community College districts was accomplished to determine if elements of California plans would be helpful in designing better plans in Florida.

Key informant interviews were conducted at 12 Florida community colleges that were members of the Florida Community Junior College Inter-Institutional Research Council. Those interviewed were made up of 12 business officers or their representatives, 6 risk managers, 8 faculty representatives, and 16 career support staff representatives. An interview instrument was used which was designed to elicit employee preferences regarding health program design, benefits covered, and assignment of costs.

The data from all the sources were recorded and analyzed to answer the questions and distinguish between options so that the feasibility of a current health program could be determined.

Conclusions

The results of this research disclosed that the insurance industry offers a wide variety of health benefit plans. Employers are also permitted to design their own programs which insurance companies agree to underwrite. This fact was demonstrated by the Florida Community College system which reported a variety of programs insured by numerous companies.

The community colleges should unite under a central program administered by the Florida Community College Risk Management Consortium. Several disclosed facts support this conclusion. The insurance "law of large numbers" confirms that the greater the number involved in a risk, the less the economic effect of a loss. This will result in reduced premium costs per employee. The number of community colleges now participating in the consortium has increased to 19. Research has revealed that seven of these colleges joined the consortium within the past calendar year because of better rate quotations even though each college continues its own uniquely designed program. The key informant respondents also strongly favored joining the central program even though some indicated that service for payment of losses would not be as efficient.

The research supports the establishment of at least two health plans by the consortium to be offered to each member college. The key informatn responses indicated that the establishment of one fee-for-service program and one HMO program would be appropriate. The conclusion can be made here that the present system of individual college designed programs is inefficient, discriminatory

respect to benefits, and should be discontinued.

Key informant responses ranked dental health protection as their first choice among proposed optional benefits. Priority should be given this benefit if cost efficient programs can be developed. Optical benefit programs created little interest and need not be included in a program if it is not desired by the employer.

It was found that all of the community colleges paid the cost of the basic health programs for its employees. Comparison with California programs disclosed that employees in California were provided with broader program options and received more help in paying dependent coverages. Although Florida law permits payment of dependent medical insurance premium by the colleges, it is generally not done. The key informant responses on this subject indicated a general agreement by the majority of employees that it was appropriate for employees to pay dependent premiums and increases. With California risk managers complaining of employee and dependent indifference to costs because all costs are paid by the college, it can be concluded that Florida community colleges should not assume dependent premium payments unless effective cost containment incentives are established.

With respect to self-insurance and specific insurance, the member colleges of the consortium are a large enough group to condust the programs on a self-insured basis. Colleges with less than 1,000 employees outside the consortium shou' not attempt a self-insured program. Because most self-funded plans still purchase some specific insurance above a specified individual loss limit and an aggregate annual maximum, self-insurance may not always be the answer to reduced insurance costs. Large groups and employers should competitively bid the alternative to arrive at the best program for the least cost.

Recommendations

It is recommended that the community colleges unite under the Florida Community College Risk Management Consortium for purposes of purchasing health programs for their employees. The consortium should design and solicit bids on two types of medical programs which it should make available to its member colleges. The first plan should be designed on a fee-for-service basis, while the second program should solicit an affiliation with a HMO.

The fee-for-service plan should be an unlimited comprehensive plan written with a $200 deductible and an 80/20% coinsurance clause. The deductible should apply to both sickness and accident claims. Maximum "out of pocket" should be $1,000 per person, $2,000 per family. This plan should be designed to include a variety of program choices for the employees. Choices should include medical and hospitaliztion, hospital indemnnity, and short- or long-term disability. This choice feature permits employees to select alternative coverages in the event they do not require basic health and hospitalization insurance.

Cost containment features are extremely important and should be included. The first three choices ranked by the key informants are crucial and should be included. The features are second-opinion required for elective surgery, pre-admission testing on an outpatient basis, and no deductible on outpatient surgery. The plan must waive the deductible with containment compliance, but require the deductible and activate a 70/30% coinsurance clause for the employee who ignores these cost containment provisions.

This fee-for-service program should affiliate with a PPO if available. The credits offered by PPOs could be passed on to the employees who utiiize

their services in the form of reduced deductibles, reduced coinsurance requirements, or "out of pocket" totals.

The consortium should request basic rate quotations on a fully insured program and on an administrative services only program. It would be the responsibility of the consortium to make the selection of the best alternative to offer the colleges. If an administrative services organization contract is established, the consortium should purchase a stop-loss aggregate contract to activate at the time losses total 120% of estimated monthly premiums. The fully insured program should be written on a retention basis with initial rates quoted for the North Florida Region (metropolitan and urban), a Central Florida Region (metropolitan and urban), and South Florida Region (metropolitan and urban). Colleges should still be separately experience rated and their final plan rates determined by applying an experience modification to their respective Florida region rates.

HMO affiliations should be solicited as the second alternative for the colleges. It would be desirable to affiliate with a network type HMO if available, but participation with GPAs and IPAs should not be excluded. It is recommended that only federally approved HMOs be recognized unless it can be determined that others are reputable and have a sound financial base.

In compliance with Florida Statute 112.0801, retirees must be allowed to continue on the college program. It is recommended that the retiree and spouse be permitted on the health plan at the same employee and spouse rates as active employees. The loss experience for this group should be combined with the loss experience of active employees. To separately experience rate this smaller group would be a disservice to the retiree.

At age 65, retirees should be encouraged to pay for medicare coverage with the college offering a medicare supplemental plan. The cost of this combined program would be less than the rates on the active college plan.

It is recommended that a dental plan be established for active employees with a $100 deductible, 80% coinsurance, and a $2,000 annual benefit limit. All types of dental work should be included in the plan, including orthodontia, periodontia, and removal of wisdom teeth.

Premium payments for all programs should be made on a monthly basis. The consortium should receive the monthly remittances from the colleges and make the necessary premium distributions. All reserve requirements negotiated with the insurance companies should be retained by the consortium as fiscal agents and invested for the benefit and at the direction of the member colleges.

All health programs should be established on a bid basis in compliance with Florida Statute 112.08. A sample specification is included.

REQUEST FOR BIDS

THE FLORIDA COMMUNITY COLLEGE RISK MANAGEMENT CONSORTIUM

ON BEHALF OF

THE FLORIDA COMMUNITY COLLEGE SYSTEM

Includes:

Comprehensive Health Insurance Plan

Health Maintenance Organization Plan

Group Life Insurance Plan

Dental Health Plan

NOTICE TO BIDDERS

The Florida Community College Risk Management Consortium is seeking bids and proposals on behalf of the Florida community colleges for employee group plans as listed below:

PART I Comprehensive Health Insurance Plan (fully insured)
Comprehensive Health Insurance Plan (self-insured with Excess Insurance--Administrative Services only)

PART II Health Maintenance Organization Plan

PART III Group Life Insurance Plan

PART IV Group Dental Insurance Plan

Bids must be received in the office of the Florida Community College Risk Management Consortium located on the campus of Sant Fe Community College, Building F-08, Gainesville, Florida, by _____(time-date)_____ to be considered. Bids received after the deadline will not be considered.

A public bid opening will be held in _____(location)_____ on _____(date)_____. Tabulation, evaluation, and final award of bids will be made on _____(date)_____.

This is not an all or none bid. Bidders may quote on any part and decline to bid on those parts in which they do not specialize.

The Florida Community College Risk Management Consortium reserves the right to accept or reject any or all bids and proposals.

If additional information is needed, please contact _____(person)_____ at the office of the Florida Community College Risk Management Consortium.

(date of specification)

General Information and Requirements

1. Any or all bidders must furnish proof of licensing by the Florida Department of Insurance upon request of the consortium. The consortium also reserves the right to request proof of financial stability by requiring financial statements or Best Insurance Rating reports on all providers and insurers.
2. Bidders submitting proposals as the "Administrative Services Only" provider in Part I must provide a certificate of approval granted by the Florida Department of Insurance which permits them to perform this service. Bidder financial statements must also be provided upon request by the consortium.
3. Rates quoted must be guaranteed for a period of one year from inception date of contract which is (inception of contract).
4. All life and health contracts let will be written on an open contract basis between the Florida Community College Risk Management Consortium on behalf of the Florida community colleges and the successful bidder(s). Cancellation of any agreements may be accomplished by either party by providing at least ninety (90) days written notice of intent to the other party. Payment of existing and future claim expense from a loss will be the responsibility of the existing insurer at the time of the loss.

5. The Florida community colleges, personnel data, and loss experience is attached for rating purposes. Bidders on Parts I, III, and IV must quote by area--North Florida (metropolitan and urban), Central Florida (metropolitan and urban), and South Florida (metropolitan and urban). After selection of insurers, individual college rates will be computed by the consortium through application of college experience modifications with approval of the insurer.
6. The North Florida Region includes (list colleges consortium designates for this area).

   The Central Florida Region includes (list colleges consortium designates for this area).

   The South Florida Region includes (list colleges consortium designates for this area).
7. The fully insured plans in Part I, III, and IV are to be written on a retention basis (no consortium coinsurance requirement) with the agreed claim reserve held by the consortium. Claim reserve limit and commission percent for insurer (based on losses paid) must be stated in bid specifications.
8. All bids for insured plans must state method of administration of claim reserves in the event of plan cancellation.
9. Bidders on Part II, Health Maintenance Organization Plan, may quote on an individual college basis. However, priority for bid award will be given to a federally approved HMO quoting on a greater network plan which develops lower overall rates for the consortium.

10. Premium payments for all plans will be on a monthly payment basis. Colleges pay health, life, and dental premiums for employees.

11. Because these bid specifications solicit proposals for both fee-for-service and HMO plans, the consortium will not estimate the number of personnel who will select each plan. It is the responsibility of each bidder to determine its own estimates. Total number of active employees is ___(#)___. Total number of employees purchasing dependent coverage is ___(#)___. Total number of retirees now insured is ___(#)___. Retirees purchasing medicare supplement is ___(#)___.

12. All brochures, identification cards, and other forms needed by the successful bidder will be provided at the insurer's expense.

13. Monthly experience reports will be furnished to the consortium office for distribution to the individual colleges.

14. Bidders must state claim procedures at the time of bid. A toll free telephone number must be provided by the insurer for claim and coverage inquiries by insured personnel.

15. Administrative Services Organizations bidding on Part I will provide a sample copy of the aggregate insurance policy with the endorsement stating that the policy assumes immediate claim payment at the time 120% of the estimated annual losses are encountered.

16. No part of these specifications will be altered or amended by the consortium without notifying all prospective bidders.

17. Bidders must include sample policies and/or contracts for service with all bids.

Awarding of Bids

The Florida Community College Risk Management Consortium reserves the right to invite potential insurers and health care providers to make oral presentations to the consortium advisory committee to clarify and confirm any bid terms prior to the award of any bid for insurance or services. Bidders will not be permitted to alter their bids or offer of services at the time of oral interview for the express purpose of defeating a competing proposal.

The consortium reserves the right to make selection of the plan or plans which it determines is in the best interest of all members of the consortium.

Bidders of the plans selected will be notified by telephone of their selection by ____(date)____. Confirmation of their selection will be in writing following the telephone notification.

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ERIC Clearinghouse for Junior Colleges
8118 Math-Sciences Building
University of California
Los Angeles, California 90024

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